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HEALTH SERVICE CORPORATIONS

1972

REPORT NO. 39
To the 43rd Legislative Assembly

MONTANA LEGISLATIVE COUNCIL
State Capitol
Helena, Montana

HEALTH SERVICE CORPORATIONS

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RECOMMENDATION

The Montana Legislative Council recommends:

1. *That the 43rd Legislative Assembly enact legislation to bring hospital and medical service corporations under the jurisdiction of the Insurance Commissioner.*

HOUSE RESOLUTION NO. 20

A RESOLUTION OF THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA DIRECTING THE LEGISLATIVE COUNCIL TO CONDUCT A COMPREHENSIVE STUDY OF THE STATUTES RELATING TO INSURANCE TO ASCERTAIN WHETHER HEALTH SERVICE CORPORATIONS SHOULD BE BROUGHT UNDER THE JURISDICTION OF THE INSURANCE COMMISSIONER.

WHEREAS, as of now, health service corporations are not under the jurisdiction of the insurance commissioner, and

WHEREAS, the said corporations are not amenable to the insurance code, Title 40, R.C.M. 1947, and

WHEREAS, these programs are similar to insurance plans now covered by the insurance code, Title 40, R.C.M. 1947, and under the jurisdiction of the insurance commissioner.

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Legislative Council is directed to conduct a comprehensive study of the insurance code statutes to ascertain whether the health service corporations which offer services similar to health insurance plans should not justifiably be brought under the jurisdiction of the insurance commissioner and submit a written report and any necessary implementing legislation to the Forty-third Legislative Assembly.

BE IT FURTHER RESOLVED, that the chief clerk of the House of Representatives is directed to send a copy of this resolution to the executive director of the Legislative Council.

INTRODUCTION

In Montana, hospital and medical service corporations are regulated as nonprofit corporations. As such, they are controlled by Title 15, R.C.M. 1947, which provides that the responsibility for supervision shall rest with the Attorney General.

Because of their nonprofit status, these corporations are exempt from the Montana insurance statutes, including the 2-3/4% insurance gross premiums tax. Stock and mutual insurance corporations which offer insurance plans similar to those provided by the hospital and medical service corporations are under the supervision of the Insurance Commissioner. In addition, even though the mutual companies operate on a nonprofit basis, both stock and mutual insurers are required to pay the gross premiums tax.

Most other states provide that hospital and medical service corporations shall be regulated by the Insurance Commissioner through either the state insurance statutes or a separate title which deals specifically with these corporations. Fifteen states also require them to pay an insurance gross premiums tax.

The bill attached as Appendix A to this report would create a separate title in the Montana statutes placing these corporations under the supervision of the Insurance Commissioner. However, under the provisions of this bill, the hospital and medical service corporations would continue to be exempt from the gross premiums tax.

The following report on hospital and medical service corporations was prepared by Dr. Patricia P. Douglas of the Bureau of Business and Economic Research at the University of Montana, at the request of the Insurance Subcommittee of the Legislative Council. Dr. Douglas presented the preliminary findings of her study to the subcommittee during a hearing held on February 26, 1972. Representatives of hospital and medical service corporations were present at that hearing.

REPORT ON MONTANA HEALTH ASSOCIATIONS

Presented to the Legislative Committee on Insurance

INTRODUCTION

This brief report covers two aspects of the financial statement of two health associations, Blue Cross and Montana Physicians Service (Blue Shield): underwriting results and solvency. The report was, in large part, prepared without the supplementary schedules and auditors' comments contained in the audit reports; and it covers only the 1965-1970 period.

Comparisons between Montana's two health associations and other insurance companies writing health and accident insurance are made in this report. Data covering other insurance companies were derived primarily from Best's Aggregates and Averages, Property-Liability published by the A.M. Best Company, one of the most reputable sources of insurance statistics. Because this source was questioned at the hearing, I have reprinted below the full description of accident and health statistics presented in the 1969 A.M. Best report (the underlined portion refers specifically to the questions raised at the hearing):

> Tabulation of the classification of admitted assets by companies, operating expenses and casualty underwriting experience by lines include a representative list of companies which, for all practical purposes, are representative of the business as a whole. Life insurance companies writing accident and health business are excluded from all tabulations unless they maintained completely segregated departments and statistics so that the separate department figures could be developed. (Emphasis added.)

Terminology used by health associations differs from that used by insurance companies. The following terms are used interchangeably in this report:

Associations	Insurance Companies
Fees earned	Premiums earned
Utilization	Claims
Reserves	Policyholders' surplus

UNDERWRITING RESULTS

Claims as a percentage of total premiums and claims plus operating expenses as a percentage of total premiums are two commonly used indicators of the underwriting results of insurance companies and health associations.

Claims as a percentage of premiums. The range for Blue Shield was 86 to 91 percent during the 1965-1970 period. Ignoring the results for 1969 when the fiscal period was changed, the range for Blue Cross was 79 to 88 percent. The range for both companies was very similar to that for 50 mutual companies writing group accident and health insurance. (Mutual companies were selected for comparison because their organizational structure closely parallels that of nonprofit health associations.)

Claims plus operating expenses as a percentage of premiums. During the 1965-1970 period, claims plus operating expenses averaged 100 percent of premiums earned for Blue Shield and 99 percent for Blue Cross. Again, this was very close to the experience of 50 mutual companies writing group accident and health insurance.

Conclusion. From 1965 to 1970, the underwriting results for Blue Cross and Blue Shield were very comparable to that of mutual companies writing group accident and health insurance.

FINANCIAL SOLVENCY

In comparison to insurance companies writing accident and health insurance, both Blue Cross and Blue Shield (particularly Blue Cross) write a very large premium volume in relation to total assets. On average, Blue Shield wrote $1.38 in premiums for every $1.00 of assets. The ratio was even higher for Blue Cross--$3.56 in premiums for every $1.00 of assets. In contrast, most insurance companies write from $.70 to $.90 in premiums for each $1.00 of assets.

Generally speaking, if an insurance company writes an abnormally high premium volume in relation to total assets, their policyholder surplus is also high in relation to total assets--the higher the risk assumption, the higher the necessary cushion (surplus). Blue Shield did, in fact, maintain reserves higher than the industry average in order to better support the company's high premium volume; policyholders' surplus averaged 62 percent of total assets during the 1965-1970 period, compared to the 26 percent industry average. For Blue Cross, however, reserves averaged only 11 percent of total assets, considerably below the industry average. Furthermore, if Blue Cross had experienced a 21 percent increase in claims during 1970, its reserves would have been reduced to zero.

Conclusion. Considering the high premium volume and the low reserves in relation to total assets, Blue Cross might, if claims rise materially, experience financial difficulties--a repeat of their experience in 1953 when they were forced to defer payments to many hospitals in the state.

Blue Shield also writes a large premium volume in relation to total assets. However, its reserve base appears to provide adequate financial support for the yearly premium volume.

ADDENDUM

REPORT ON MONTANA HEALTH ASSOCIATIONS

Information contained in the financial statements of Blue Cross and Blue Shield does not provide a conclusive case for or against the regulation and taxation of these two associations. Financial data can be interpreted in many ways and it is difficult to prove which interpretation is the "correct" one. Furthermore, the justification for not taxing or regulating these associations developed from some historical circumstances rather than from the nature of their financial position. This addendum summarizes the limitations of financial data and discusses the historical justification for the current regulatory and tax status of Blue Cross and Blue Shield. In addition, this addendum provides some arguments for changing the current tax and regulatory status of these associations.

LIMITATIONS OF FINANCIAL ANALYSIS

In general, accounting procedures and, more specifically, types of expenses incurred vary by type of company and by type of insurance written. For example, the health and accident section of the 1969 A.M. Best report shows statistics for two types of companies (stock and mutual) and two types of policies (group and all other). Claims as a percentage of total assets or operating expenses as a percentage of total assets varied considerably among these four accident and health classifications. For example, operating expenses as a percentage of total premiums varied from a high of 38.8 percent (stock companies writing other accident and health policies) to a low of 10.9 percent (mutual companies writing group accident and health). Trying to select one of these four (or an average of all four) as a standard against which to measure the performance of Blue Cross and Blue Shield is a difficult task, and the selection of any single one, or the average of all four, is open to question.

The same is true of the other criterion of underwriting performance, claims as a percentage of total premiums. The 1969 A.M. Best report referred to earlier shows that the ratio of claims to total premiums ranged from 51.1 percent (stock companies writing other accident and health) to 88.6 percent (mutual companies writing group accident and health).

That the sample with the highest expense ratio (stock companies writing other accident and health) also shows the lowest underwriting ratio is no accident. The sample with the lowest expense ratio also has the highest underwriting ratio! These statistical variations reflect differences among types of companies and types of insurance. Therefore, as pointed out earlier, it is difficult to pick one measure of performance or one type of company against which to examine the performance of Blue Cross and Blue Shield.

Because the measures cited above lack comparability, a better

standard of performance is underwriting profit or loss (total premiums less operating expenses and claims) as a percentage of premiums earned. As exhibit 1 shows, neither Blue Cross nor Blue Shield consistently out-performed mutual and stock insurance companies writing accident and health insurance. It is still impossible, however, to determine from these underwriting results whether or not Blue Cross and Blue Shield should be regulated or taxed. That determination requires an examination of the historical development of these associations as well as the current need to monitor health delivery systems at the state level.

HISTORICAL DEVELOPMENT OF THE BLUES

Blue Cross and Blue Shield plans were first initiated during the 1930s when private carriers were not offering surgical and hospital benefits. Understandably, then, these plans were given special regulatory and tax treatment; they provided hospital and surgical coverage at a time when many people desperately needed the service. But the offerings of private carriers have expanded considerably since then, and now include policies similar to those offered by the Blues.[1]

Should Montana continue to provide preferential tax and regulatory status to one type of carrier providing hospital and surgical benefits? Answering the question affirmatively implies: 1) that the benefits provided by the Blues can be easily distinguished from that provided by insurance companies and/or; 2) these associations have some unique organizational or operational characteristics. Neither implication has any emperical support. The Blues frequently argue (as they did in the hearing on February 26) that they compete directly with all other companies offering health and accident insurance; then their benefits cannot be too unique. Then, too, the "nonprofit" status is certainly not unique to them since mutual insurance companies operate on this same basis.

[1]Consider the analogy of commercial banks and savings and loan associations. Savings and loan associations (S & Ls) began at a time when commercial banks were providing poor service to the small saver. Thus, S & Ls filled a desperately needed void in the area of financial services and were, accordingly, given special tax treatment and regulatory status. But gradually banks began offering services to the small depositor and S & Ls began competing directly with commercial banks. As these changes have occurred so has the regulatory and tax status of S & Ls: in 1966 they were first subjected to direct controls on rates paid depositors and, in 1951, they began paying federal income taxes. The analogy illustrates that the federal government and state governments as well frequently use taxation and regulatory controls as incentives for firms to provide needed public services. But when the incentives are no longer needed or when they impede free competition, they should be changed.

EXHIBIT I

Underwriting Profit (Loss) as a Percent of Total Premiums Earned
Selected Insurance Companies and Health Associations
1965-1970

	Blue Cross[a]	Montana Physicians Service[b]	Stock (Group)[c]	Stock (Other)[c]	Mutual (Group)[d]	Mutual (Other)[d]	All Health[e]
1965	.8	(.8)	(.5)	5.9	---	1.0	N.A.
1966	1.1	2.9	1.6	9.4	1.9	(.2)	2.2
1967	8.3	3.2	(.1)	13.2	2.3	(.1)	1.6
1968	1.1	(.2)	1.5	9.6	.7	(4.5)	.5
1969	(.7)	(.8)	.4	7.8	(1.0)	(2.5)	(1.2)
1970	1.2	(.6)	N.A.	N.A.	N.A.	N.A.	(2.8)

[a]Derived from the audited financial statements of Blue Cross.

[b]Derived from the audited financial statements of Montana Physicians Service.

[c]Stock companies writing group or other accident and health insurance; Best's Aggregates and Averages, Property-Liability (New York: A.M. Best Company, 1970), p. 140.

[d]Mutual companies writing group or other accident and health insurance; Best's Aggregates and Averages, Property-Liability (New York: A.M. Best Company, 1969 and 1970), p. 211 (1969) and p. 199 (1970).

[e]Hearing before the Montana Legislative Council Committee on Insurance, February 26, 1972. (Notation shows Argus Chart of Health Insurance.)

Some associations, Blue Cross in Montana, are unlike insurance companies in one respect: they maintain low reserves in relation to total assets. According to these associations, substantial reserves are unnecessary because hospitals and physicians represent their "cushion against catastrophy," i.e., if the going gets tough, hospitals simply do not collect the fees. If that is, in fact, always true, then one can turn the argument around and suggest that other health associations who maintain high reserves, Blue Shield in Montana (with its reserves of 62 percent of total assets), are overcharging the consumer and operating much like a profit-making firm does when it builds up retained earnings.

The point is: if reserves are not needed, fine, regulate the associations so that the public can be assured of minimum charges. If, on the other hand, reserves are necessary, then there is no difference between these associations and other insurance companies; regulatory controls should be imposed to insure adequate protection for the subscribers.

One can argue both sides of the issue, but one cannot support both positions simultaneously--one minute arguing that reserves are unnecessary in view of the relationship with hospitals and/or doctors, and the next maintaining that an underwriting gain is important in order to build up the required reserves.

MONITORING THE HEALTH DELIVERY SYSTEM

As was pointed out during the hearing, the federal government may institute some form of national health insurance. Until then, and even afterwards, the states have a responsibility to monitor the health delivery system. Part of that system is now controlled via regulations on insurance companies operating within state boundaries. But one part, that relating to the nonprofit health associations, is not controlled. Since the doctors and hospitals providing the service also play an important role in determining fees charged and the like, a careful monitoring system is, in my opinion, absolutely necessary. A few basic policy questions are listed below:

1. How effectively does the utilization review process work in Montana? There is evidence that in some states substantial overutilization of hospital and medical facilities occurs.

2. What kinds of costs are included in the fee schedule? Some associations do not directly reimburse for research costs. There is reason to believe, however, that in some states research costs may be comingled indirectly with patient care and thus become reimbursable.

3. What basis does Blue Cross, for example, use in selecting hospitals? Does that selection process include such things as a review of

the hospital budget, insistence upon uniform accounting practices, and implementation of cost-savings devices?

4. Are hospitals and physicians disclosing their financial and operational details (related to Blue Cross and Blue Shield programs) to the public? The published financial reports that I have seen are certainly not an adequate public explanation of either plan.

5. What consideration has been given to protecting the public from improper charges? Patients may be charged for hospitalization they do not need, or for brand name drugs when generic drugs would be less costly.

This list could be expanded, but even this limited list indicates that if Montana intends to monitor the health delivery system in this state, these questions must be answered to the satisfaction of the public who subscribes to these plans. I doubt that these questions can be answered without direct regulatory controls over both associations.

APPENDIX A

_____BILL NO._____

INTRODUCED BY_____

A BILL FOR AN ACT ENTITLED: "AN ACT FOR A NEW CHAPTER IN TITLE 40, R.C.M. 1947, PROVIDING FOR THE REGULATION OF NONPROFIT HOSPITAL, MEDICAL-SURGICAL AND HEALTH SERVICE ORGANIZATIONS."

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF MONTANA:

Section 1. Purpose. It is the policy of the Legislative Assembly, and the intent and purpose of this chapter to promote the availability of and regulate hospital care, medical-surgical care, dental care, and other health services on a voluntary non-profit prepaid basis, and to thereby promote and protect the health and welfare of the people of the state of Montana.

Section 2. Definitions. In this chapter, unless the context otherwise requires:

(1) "Hospital service plan" shall mean any form of organization or any arrangement whereby any person or corporation undertakes responsibility to provide:

(a) maintenance and care in a hospital including but not limited to nursing care, drugs, medicines, supplies, psychotherapy, transportation and use of facilities and appliances;

(b) reimbursement of the beneficiary or subscriber for, but without requiring that he first pay, expenses incurred for any of the above items or the costs and expenses incurred for professional medical services rendered during hospitalization.

(2) "Health care service plan" shall mean any form of organization or arrangement whereby any person undertakes responsibility to provide, arrange for, pay or reimburse any part of the cost of any health care service for a consideration consisting in part of prepaid or periodic changes.

(3) "Health care service" means any service included in the furnishing to any person of medical, surgical or dental care treatment; or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of services purporting to constitute any system of alleviating, curing, or healing human illness or injury.

(4) "Member" shall mean a person who has been enrolled as a subscriber or a family dependent of a subscriber to a

hospital or health care service plan and is entitled under the membership contract issued by such plan to receive health care services.

(5) "Contract" shall mean any contract, or in the absence of a written contract, any other written description of rights and benefits enjoyed by members of the plan, issued by a hospital or health care service corporation.

(6) "Advertising" shall mean communication to the public or any segment thereof by means of radio, television, newspaper, magazine, periodical, brochure, pamphlet, circular, or any other means, information purporting to relate to or describe a service plan or the costs or benefits thereof, if such communication is intended to cause, or may reasonably be expected to cause, recipients to become interested in becoming members of a service plan; provided however, that annual reports, written addresses, articles, statistical reports, reports of surveys or research studies and similar documents shall not be deemed to constitute advertising unless used for the purpose of attracting members to enroll in a service plan.

(7) "Solicitation" shall mean any communication, written or oral, in person or by means of telephone, radio, television, newspaper, magazine, periodical, brochure, circular, or otherwise, of any offer of coverage in a service plan, or invitation, or request to enroll in a service plan, or attempt to obtain consideration for the coverage of a service plan, or any other device, the apparent purpose or reasonable effect of which would be to induce the recipient thereof to enroll in, or pay any consideration for the coverage provided by, a service plan.

Section 3. Incorporation and organization--exemptions. (1) Any nonprofit corporation heretofore or hereafter organized under the laws of the state of Montana for the purpose of establishing, maintaining, and operating a nonprofit plan, whereby prepaid hospital care, medical-surgical care, and other health services are made available to persons who become subscribers to such plan or plans under a contract with the corporation, shall be subject to and be governed by the provisions of this chapter, and, except as hereinafter otherwise specifically provided, shall not be subject to the laws of this state relating to insurance or insurance companies.

(2) The provisions of this chapter shall not apply to any hospital or health care service plan operated by an insurer, or a fraternal benefit society, while such plan is so operated within the scope of the current certificate of authority issued by the insurance commissioner and governed by the state insurance code, or to such a plan operated under a trust fund negotiated by collective bargaining between an employer and a labor organization, as those terms are defined below or established and operated by an employer for his employees; provided that:

(a) The charges for the hospital or health care service

are paid entirely by the trust fund, or entirely by the employer, or jointly by employer and employees; and

(b) No persons other than employees of the employer, or their family dependents, are eligible to become members of the hospital or health care service plan, and

(c) The plan is not advertised nor solicited except to persons eligible to subscribe to the plan. "Employer" shall mean any person acting directly as an employer or indirectly in the interest of an employer in relation to an employee hospital or health care service plan, and includes a group or association of employers acting for an employer in such capacity. "Labor organization" shall mean any labor union which exists for the purpose, in whole or in part, of negotiating with an employer concerning an employee hospital or health care service plan, or other matters incidental to employment relationships. "Employee" shall mean any individual employed by an employer, or any family dependent of such individual.

(3) This chapter shall not apply to nor govern any corporation which is organized for profit, which contemplates any pecuniary gain to its shareholders or members, or which conducts or is authorized by its articles of incorporation to conduct any business whatsoever on a profit basis. This chapter shall not authorize nor be construed to authorize, directly or indirectly, any corporation to operate a hospital or health service plan on a profit basis. No corporation subject to the provisions of this chapter shall own or operate any hospital nor engage in any business other than that of establishing, maintaining and operating a nonprofit hospital or health service plan.

Section 4. Formation of nonprofit hospital and health care service plan corporations. (1) Any corporation heretofore or hereafter organized under the laws of the state of Montana without capital stock for the sole purpose of maintaining and operating a hospital or health care service plan, as provided in this chapter, and which does not contemplate pecuniary gain or profit to its members, may undertake and operate a plan for rendering hospital, medical-surgical or health care service to its subscribers under and subject to the provisions of this chapter.

(2) Persons desiring to form a nonprofit hospital or health care service corporation shall incorporate pursuant to the provisions of this chapter and the provisions of Title 15, chapter 23, R.C.M. 1947, so far as the provisions of said chapter 23 are applicable and not inconsistent with this chapter.

(3) In addition to the contents required or permitted by the general corporation laws of this state relating to nonprofit corporations, the articles of incorporation of any corporation shall comply with the following:

(a) The name of the corporation shall not include the words "insurance," "casualty," "surety," "mutual," or any other words

descriptive of the insurance, casualty, or surety business. The corporate name of any corporation to be formed under this chapter shall not be the same as, or deceptively similar to, the name of any other corporation authorized to do business in this state; and

(b) The statement of purposes shall be in conformity with the provisions of this chapter.

(4) Any such corporation heretofore organized whose existing articles of incorporation shall not be in substantial conformity with this chapter shall forthwith cause to be adopted and filed, as herein required, such amendments thereto as shall be necessary to effect substantial compliance herewith.

(5) The property and lawful business of every such corporation subject to the provisions of this chapter shall be held and managed by a board of trustees or directors with such powers and authority as shall be necessary or incidental to the complete execution of the purposes of each such corporation as limited by its articles or the bylaws. No such board shall be less than ten (10) nor more than twenty-four (24) in number.

Section 5. Certificate of authority. (1) No corporation shall establish, maintain or operate a nonprofit service plan as authorized by the provisions of this chapter unless it shall first have procured a certificate of authority from the commissioner of insurance of this state for the establishment, maintenance and operation of said service plan.

(2) No corporation subject to the provisions hereof shall deliver or issue for delivery in this state any subscription certificate or membership certificate describing the health benefits available thereunder, or any endorsement, rider, or application which becomes a part thereof, until a copy of the form and the schedule of rates, dues, fees, or other periodic charges applicable thereto, to be paid by subscribers or members, have been filed with the commissioner; nor shall any such certificate, endorsement, rider, or application be used until the expiration of thirty (30) days after the filing thereof, unless the commissioner shall sooner give his written approval thereto. The commissioner shall notify, in writing, the corporation which has filed any such form if it does not comply with the requirements of law, or if it contains any provision which is deceptive and ambiguous or misleading, specifying the reasons for his opinion. In all other cases the commissioner shall give his approval.

(3) After the expiration of such thirty (30) days from the filing of any such form, or at any time after having given written approval thereof, the commissioner, after a hearing of which at least ten (10) days written notice has been given to the corporation issuing such form, may withdraw approval if he finds said form is being offered to the public by means of advertising, communications, or dissemination of information which is deceptive

or misleading. Such disapproval shall be effected by written order of the commissioner, which shall state the grounds for disapproval and the date, not less than thirty (30) days after such hearing when the withdrawal of approval shall become effective.

Section 6. Conditions for issuance of certificate of authority. The commissioner of insurance shall not issue or renew his certificate of authority to any corporation proposing to establish, maintain or operate a nonprofit service plan until such corporation shall have established:

(1) That with regard to hospital service corporations the corporation has entered into contracts with hospitals in the state of Montana, holding certificates of approval issued by the state department of health and environmental sciences, and having an aggregate bed capacity sufficient to render the services contemplated to be furnished under the hospital service plan to persons in the state of Montana.

(2) That the contract proposed to be entered into by such corporation with those who may become subscribers is not such as will work a fraud or injustice upon such subscribers or any person.

(3) That a schedule of rates, dues, fees or other periodic charges to be paid by subscribers has been filed with the commissioner. The same shall not be such as will, after providing for such legal reserves as are required by section 9 of this chapter, result in profit to, or in the accumulation of excessive reserves or surpluses by such corporation and are such as will enable such corporation to furnish or provide the services which it proposes to make available to its beneficiaries and subscribers without impairment of its legal reserves and without a constant depletion of the assets of such corporation. A reserve or surplus over and above all approved and required reserves in an amount in excess of the average annual gross income of such corporation for the immediately preceding three (3) calendar years shall be prima facie an excessive accumulation.

Section 7. Filing annual operating statement. Every corporation subject to the provisions of this chapter shall annually, on or before March 1, file in the office of the commissioner a statement verified by at least two (2) of the principal officers of said corporation, showing its condition and affairs as of the December 31 then next preceding, which shall be in such form as shall be required by said commissioner and shall contain statements relative to the matters required to be established as a condition precedent to maintaining or operating a nonprofit service plan and to other matters as said commissioner shall prescribe.

Commencing with the annual statement to be filed on or before March 1, the commissioner shall require the payment of a fee for filing such statement. On or before February 1, the commissioner shall certify to each such corporation holding a certificate of

authority under section 5, the amount of the fee to be paid by it pursuant to this section. The total amount of fees and charges to be collected by the commissioner from corporations subject to this chapter shall be determined by the commissioner according to the schedule contained in section 40-2726, R.C.M. 1947.

Section 8. All acquisition costs in connection with the solicitation of subscribers to such service plans shall at all times be subject to the approval of the commissioner of insurance, and the administrative expenses for any calendar year of any such corporation organized under this chapter, including acquisition costs, shall be limited to twenty-five percent (25%) of the aggregate amount of rates, dues, fees and other periodic charges actually received during that year. If the commissioner shall find that the administrative expenses exceed the amount above stated, such finding shall be sufficient ground to justify the commissioner in revoking his consent to the establishment, maintenance and operation by such corporation of the service plan.

Section 9. Reserves. (1) No corporation subject to provision of this chapter shall be permitted to do any business in this state unless, in addition to the other requirements of law, it shall have and maintain liquid reserves in an amount not less than five percent (5%) of the corporation's subscription income collected in the preceding year not exceeding two million dollars ($2,000,000), plus two and one-half percent (2-1/2%) of such income exceeding two million dollars ($2,000,000) but not exceeding ten million dollars ($10,000,000), plus one percent (1%) of such income exceeding ten million dollars ($10,000,000); but, in no event shall such reserves be less than fifty thousand dollars ($50,000). All corporations subject to the provisions of this chapter shall place on deposit with the commissioner a guarantee fund of cash or approved securities in an amount determined by such formula, but not less than fifty thousand dollars ($50,000) nor more than one hundred fifty thousand dollars ($150,000). Any amount of said liquid reserves required by this subsection in excess of one hundred fifty thousand dollars ($150,000) shall be maintained by the corporation at all times, but shall not be required to be placed on deposit with the insurance commissioner.

(2) The cash or securities representing the guarantee fund required by this section shall be deposited with the commissioner who shall give receipts for all securities so deposited with him to the corporation depositing them. It shall be the duty of the commissioner upon the receipt of such securities to forthwith deposit the same in the presence of an authorized officer of the depositing corporation, in a safety deposit box, accessible only to the commissioner or his representative who may be an employee of the insurance department or a designated trust officer of the depository and an authorized officer of the corporation, in the vault of any bank, trust company, or safety deposit company in the state of Montana to be selected by the commissioner, and the depositing corporation shall pay the several fees for such boxes. So long as the depositing corporation shall continue solvent the

commissioner shall permit such corporation to collect and receive the interest and dividends on the securities so deposited, and from time to time, withdraw any such securities on depositing other acceptable securities in the place of those so withdrawn. If the commissioner shall willfully fail, refuse, or neglect to faithfully keep, deposit, and account for any such securities received by him, or shall willfully fail, refuse, or neglect to furnish proper certificate of securities so held by him, the commissioner shall be responsible therefor upon his official bond, and suit may be brought upon said bond by any person damaged by such failure, refusal, or neglect.

Section 10. Contracts. (1) No contract shall be entered into between a corporation proposing to furnish or provide any one or more of the services authorized under this chapter and a member:

(a) Unless the entire consideration therefore is expressed in the contract;

(b) Unless the times at which the benefits or services to the subscriber take effect and terminate are stated in a portion of the contract above the evidence of its execution;

(c) Unless every printed portion and any endorsement or attached papers are plainly printed in type of which the face is not smaller than ten (10) points;

(d) Unless, if any portion of such contract purports, by reason of the circumstances under which an illness, injury or disablement is incurred to reduce any service to less than that provided for the same illness, injury or disablement incurred under ordinary circumstances, such portion is printed in boldface type and with greater prominence than any other text of the contract;

(e) If the contract contains any provisions purporting to make any portion of the charter, constitution or by laws of such nonprofit corporation a part of the contract unless such portion is set forth in full in the contract;

(f) Unless such contract for service contains in blackface type not less than ten (10) point the following provisions;

Nothing in this contract contained shall in any way or manner restrict or interfere with the right of any individual entitled to hospital or health care service hereunder to select the contracting hospital or to make a free choice of his attending physician, who shall be a duly licensed physician, osteopath, chiropractor, optometrist, chiropodist, or dentist.

(2) Corporations subject to the provisions of this chapter may enter into contracts for the rendering of hospital services, medical-surgical services, dental services and other health services on behalf of any of their subscribers with hospitals

maintained by the state, or by any of its political subdivisions, or maintained by a nonprofit corporation organized for hsopital purposes, or with other corporations, associations, partnerships, or individuals furnishing hospital services, medical-surgical services, dental services, or other health services. Nothing contained in this chapter shall require any such corporation to contract or remain under contract with any individual hospital, physician, or other purveyor of health services; nor shall any employee, agent, officer, or trustee of any such corporation influence or seek to influence any subscriber in the choice or selection of a contracting hospital or contracting physician, or any other contracting purveyor of health services, except, that nothing in this chapter shall prevent any such nonprofit corporation which has subscribers or members solely from one industry, from contracting with any physician or physicians to provide medical, surgical, and other health services to such subscribers or members and their immediate families, nor prevent such corporation from specifying or recommending any physician or physicians to render such services to its subscribers or members and their immediate families, for any particular type or types, or classification or classifications, of medical, surgical, dental or other health care.

Section 11. Enrollment representative defined. A person who, for compensation, solicits subscription to or the establishment of membership in a prepayment plan offered by a corporation subject to the provisions of this chapter or transmits for a person other than himself an application for such subscription or membership, or offers or assumes to act in the negotiation thereof shall be an enrollment representative or agent within the intent of this chapter.

Section 12. Licensing of representatives. Every corporation subject to the provisions of this chapter shall notify the commissioner through its proper officer or agent of the name, title, and address of each person it desires appointed to act as the corporation's enrollment representative or agent. The notice shall be accompanied by an application from the appointee, and shall be in writing upon a form furnished by the commissioner. If upon receipt of such written notice, when accompanied by the fee required by the commissioner according to the schedule contained in section 40-2726, R.C.M. 1947, it appears that the appointee is a competent and suitable person who intends to hold himself out in good faith as the corporation's agent, and that he qualifies under the provisions of this section, the commissioner shall issue to such appointee a license which shall state in substance that the person named therein is a constituted enrollment representative or agent of the corporation in this state. The commissioner may at any time prior to the granting of such license require an appointee to submit to an examination, in a form prescribed by the commissioner, on the qualifications of such person to act as an enrollment representative or agent in this state.

Section 13. Renewals of licenses. If for cause shown, and

after a hearing or examination the commissioner shall determine any person to be unsuitable to act as an enrollment representative or agent, he shall thereupon refuse to issue a license or shall revoke any license previously issued, and shall notify in writing both the appointee and the corporation of such refusal. Unless revoked by the commissioner or unless the corporation by written notification to the commissioner cancels the authority of an agent or representative to act for it, any license issued or any renewal thereof shall expire on January 1 after its issuance and may be renewed annually upon payment of the annual license renewal fee as provided for in section 40-2726.

Section 14. Examinations and investigations. The commissioner, or any person authorized by him, shall have the power to examine the financial condition, affairs, and management of any corporation subject to the provisions of this chapter. For such purpose he shall have free access to all the books, papers, and documents relating to the business of the corporation, and may summon witnesses and administer oaths and affirmations in the examination of the directors, trustees, officers, agents, representatives, or employees of such corporation, or any other person in relation to its affairs, transactions, and conditions. The commissioner shall make an examination of each corporation subject to the provisions of this chapter at least once every three (3) years, and the corporation examined shall pay to the commissioner a fee as determined by the commissioner for making such examination according to the schedule contained in section 40-2726(a)(ii), R.C.M. 1947.

Section 15. Revocation of certificate--appeal. (1) The commissioner shall not make public the result of any examination or investigation of any corporation found to be insolvent, or with its capital impaired prior to suspending or revoking the authority of such company to do business in this state. If the commissioner determines, after examination, hearing, or other evidence, that such corporation is in an unsound condition, or has failed to comply with the law, or with the provisions of its charter, or that its condition is, or its methods are, such as to render its operations hazardous to the public, or to its subscribers, or that its actual assets, exclusive of its capital, are less than its liabilities, or if its officers or agents refuse to submit to examination, or to perform any legal obligation relative thereto, or refuse on behalf of the corporation to pay the examination charges, he shall suspend or revoke all certificates of authority granted to said corporation, and to its officers or agents, and shall cause notice thereof to be published in daily newspapers published in the major cities of the state, and no solicitation of new business shall thereafter be done by it or its agents in this state, while such default or disability continues, nor until its authority to do business is restored. Before suspending or revoking the certificate of authority of any such corporation, unless it is insolvent or its capital impaired, the commissioner shall grant fifteen (15) days in which to show cause why such action should not be taken.

(2) A corporation whose certificate of authority has been suspended or revoked by the commissioner may appeal within fifteen (15) days after such order to a district court of the state, which court, upon the filing of the proper petition, shall cause the records and orders of the commissioner to be brought before it, and upon hearing of the case the court shall by its final decree either affirm or reverse and vacate the order of the commissioner.

(3) The court shall have the power to make an order suspending or staying the order of the commissioner suspending or revoking the license of a corporation pending the appeal; but the corporation appealing shall give a bond, with sureties satisfactory to the court, in such amount as the court determines to be just and proper, conditioned to pay to the state and to any and all persons whomsoever any and all loss that may be sustained by reason of the stay or suspension of such order of said commissioner, and that during the period allowed for taking such appeal, the publication of notice of the revocation or suspension of license of such corporation as provided by this section, shall not be made. If the order of the commissioner has been stayed or suspended by the order of said court, such publication shall not be made until after the discharge of such stay or until the affirmation of such order or revocation or suspension.

(4) Upon appeal, the corporation shall be entitled to a trial by jury upon all issues of fact. If the trial is by jury, the court shall submit to the jury specific issues to be determined by jury covering the matters in issue separately, and the jury shall return a special verdict upon each issue submitted, and if by such verdict it shall be found that the corporation, association, or society is insolvent because of obligations due and unpaid which exceed its assets, the court may render judgment that it be enjoined from exercising any corporate rights, privileges, or franchises in this state.

(5) (a) In the event of such a finding of insolvency, the commissioner shall have and exercise all of the powers and authorities set forth in Title 40, chapter 51, R.C.M. 1947.

(b) If no charge of insolvency is made, or, if made, is not established by the verdict of the jury, but it shall be found by such verdict that the corporation, association, or society has exceeded its corporate powers or failed to comply with any provisions of this chapter or has done or committed any act for which its license may be revoked or suspended under any of the provisions of this chapter, or has conducted its business unlawfully or fraudulently, the court may make and enter judgment enjoining and restraining it from the commission of such acts or such of them as the court may determine, and in case of failure to desist therefrom within the time to be specified in such judgment, that the corporation be perpetually enjoined from doing any further business in this state. Pending the trial if no bond has been given as provided, upon motion of the attorney general and upon notice to the corporation, association, or society, the

court may grant an injunction restraining it and its officers from collecting any debt, or demand and from paying out or in any way transferring or delivering to any person any money, property, or effects, during the pendency of the proceedings except by direction of the court, and may appoint one or more temporary receivers in such cases. From the decree of said district court an appeal shall lie to the supreme court; and it shall be the duty of the district court and of the supreme court to advance the hearing of said matter as far as justice and the business of the court may permit.

Section 16. Suspension or revocation of certificate. The commissioner may suspend or revoke the permission granted by section 5 if, subject to the appeal provisions of the last section, he finds that the corporation has:

(1) Misrepresented the conditional nature of the coverage;

(2) Neglected or refused either to cancel or otherwise terminate such coverage within the time required by such section;

(3) Shown a lack of diligence in making revisions in the contract or certificate necessary to obtain its approval by the commissioner;

(4) Failed so often in so many important respects in drafting any such contract or certificate to conform to the applicable requirement of this chapter that a conclusion of lack of good faith or competency in drafting is reasonably justified;

(5) Circulated announcements of coverage to individual subscribers which failed to advise them of the conditional nature of the coverage; or

(6) If any service plan or representative of a service plan knowingly permits the use of advertising or solicitation which is untrue or misleading, or any form of membership contract which is deceptive.

Section 17. Complaints. Any individual subscriber of a corporation subject to the provisions of this chapter who believes himself to be aggrieved by any act or omission of such corporation or its officers, directors, agents, or representatives, may file a statement in writing of his grievance in the office of the commissioner and the commissioner may make such investigation of such grievance as he deems appropriate. No such investigation by the commissioner shall act as a bar to any suit in a court of competent jurisdiction instituted by any such member or subscriber, or any defense thereto by the corporation involved.

Section 18. Regulations. In the implementation of this chapter, the commissioner may, after notice and hearing, promulgate such reasonable rules and regulations not inconsistent with the provisions of this chapter, as he shall deem necessary for the proper administration of this chapter.

Chapter 19. Exemption of direct payment methods. Nothing contained in this chapter shall be construed to affect or apply to hospitals, or other licensed health care institutions, nor to any individuals, partnerships, associations, or corporations which are the direct purveyors of health services; nor shall anything contained herein be construed to in any way limit the rights of such hospitals, or other licensed health care institutions or purveyors of health services to establish methods of payment directly with the purchasers of their services; but the commissioner may require from any such institution or purveyor of service such information as will enable him to determine whether any such arrangements for payment for services are subject to the provisions of this chapter.

Section 20. Contracts with other organizations. Any corporation subject to the provisions of this chapter may contract with any agency, instrumentality, or political subdivision of the United States of America, or of the state of Montana for the making available of hospital, medical-surgical, dental and other health care services, and in aid or furtherance of such contract may accept, receive, and administer in trust, funds directly or indirectly made available by such agency, instrumentality, or political subdivision. Any such corporation may also subcontract with any organization which has contracted with any agency, instrumentality, or political subdivision of the United States of America, or of the state of Montana for the furnishing of hospital, medical-surgical, dental or other health services by which subcontract such corporation undertakes to furnish the services specified by the basic contract. Any corporation subject to the provisions of this chapter may also enter into agreements or contracts with other similar organizations or corporations licensed to do business in this state or any other state for the transfer of subscribers or members, for the reciprocal or joint provision of benefits to the subscribers or members of such corporation and such organizations or such other joint undertakings as the corporation's board of directors or trustees may approve.

Section 21. Taxes. Every nonprofit service corporation organized or admitted under this chapter and all of its funds shall be exempt from all and every gross premium tax or tax provided for in section 40-2821, R.C.M. 1947.

Section 22. Effective date. This chapter shall take effect on July 1, 1973, but any corporation organized prior to the passage of this chapter, under the laws of the state of Montana relating to corporations not for profit, for the purpose of administering, maintaining, and operating a service plan, as described in this chapter, shall be allowed a period of one (1) year after the effective date of this chapter to make the applications and filings and to meet the requirements set forth in this chapter provided, that any corporation organized prior to the passage of this chapter shall be allowed a period of four (4) years after the effective date of this chapter to meet the requirements of section 9, Reserves.